BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
David Shenassa, M.D.	)	**File No. 800-2016-028436**
Physician's and Surgeon's Certificate No. A 102331	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 16, 2018.

IT IS SO ORDERED January 17, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAVID SHENASSA, M.D. Physician's and Surgeon's Certificate No. A 102331, Respondent.	Case No. 800-2016-028436 OAH No. 2017060277

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on November 2, 2017, in Oakland, California.

Supervising Deputy Attorney General Jane Zack Simon represented complainant Kimberly Kirchmeyer, the Executive Director of the Medical Board of California, Department of Consumer Affairs.

Robert W. Hodges, Attorney at Law, McNamara, Ney, Beatty, Slattery, Borges & Ambacher LLP, represented respondent David Shenassa, M.D., who was present.

The record closed and the matter was submitted on November 2, 2017.

FACTUAL FINDINGS

1. On December 14, 2007, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 102331 (certificate) to respondent David Shenassa, M.D. The certificate expired on April 30, 2017, and has not been renewed.

2. On March 3, 2017, complainant Kimberly Kirchmeyer, acting in her official capacity as Executive Director of the Board, issued an accusation against respondent. The accusation alleges that respondent's certificate is subject to discipline because of actions taken by the State of Florida Board of Medicine (Florida Board) against respondent's license to practice medicine in Florida. Respondent requested a hearing, and this hearing followed.

Respondent's background

3. Respondent received his medical degree from the Technion – Israel Institute of Technology. He completed his internship and residency in the Department of General Surgery at the North Shore Long Island Jewish Health System, New York University/Albert Einstein School of Medicine. He was Chief Resident from 2007 to 2008. In 2009, he completed the Joseph H. Boyes Hand Fellowship Program in the Department of Orthopedic Surgery at the University of Southern California, Keck School of Medicine. From 2008 to 2009, respondent worked at Kaiser Permanente in Fontana, California, as a per diem general surgeon. Respondent has a license to practice medicine in New York, but it is not active.

4. Since 2009 respondent has practiced as a hand, wrist and microvascular surgeon at the Sports Medicine Associates of South Florida. Respondent performs 450-500 surgical procedures per year, and most of them are elective. He is currently the Vice-Chair of the Board of Directors of the University Hospital in Taramac, Florida. Respondent is in the process of becoming board certified; he has passed the written examination and will be taking the oral examination in April 2018.

Action by the Florida Board

5. On a date not established by the record, the Florida Board issued to respondent a license to practice medicine (Florida Medical License No. ME 105233).

6. On December 7, 2016, the Florida Board issued a Final Order reprimanding respondent's license. The Final Order resolved a pending administrative complaint against respondent that alleged that he had performed a wrong site finger surgery on a 10-year-old patient on December 1, 2014. Pursuant to the Final Order issued by the Florida Board, the disposition of respondent's case included requirements that he pay a fine of $7,500; pay costs in the amount of $4,256.10; present a lecture to surgical staff that addresses the subject of wrong site surgery; engage a certified licensed risk manager to review his current practice and issue a quality assurance report to the Florida Board; and, that he complete continuing medical education. The Settlement Agreement that was presented to the Board for approval contained a probation requirement, but the Final Order deleted the requirement that respondent's certificate be placed on probation.

Matter in aggravation (prior discipline)

7. Pursuant to a Stipulated Settlement and Disciplinary Order, effective July 17, 2014, petitioner's certificate was publicly reprimanded. The public reprimand was based upon a Final Order issued by the Florida Board, filed on October 16, 2013, which adopted a settlement agreement, under which a Letter of Concern was issued. The Final Order resolved a complaint that respondent had performed a wrong site surgical procedure on a patient's finger and that he failed to take steps to prevent wrong site surgery. Pursuant to the terms of

the settlement agreement, incorporated into the Final Order, respondent was required to complete courses in medical and legal ethics and risk management, and to present a lecture on wrong site surgeries at an approved medical facility.[1]

Respondent's evidence

CIRCUMSTANCES SURROUNDING WRONG SITE SURGERY ON DECEMBER 1, 2014

8. The circumstances surrounding the wrong site surgery on December 1, 2014, are as follows: Respondent successfully performed a closed reduction of the proximal phalanx fracture of the patient's left middle finger, which was the correct site. After he placed the k-wire into the correct site, respondent had an x-ray taken to confirm that the wire had been properly placed. Respondent reviewed the x-ray and, because he was not pleased with the placement of the k-wire in the patient's finger, he removed it. Respondent then changed his position to re-insert the k-wire. When he re-inserted the k-wire, he placed it in the patient's left ring finger, which was the wrong site.

9. Respondent did not realize his mistake until he saw the patient in his office two days after the surgery. He removed the wire from the wrong finger and placed a cast on the correct site. The patient discontinued treatment with respondent and sought treatment elsewhere.

10. The patient fully recovered without any disability. No medical malpractice claim was filed in connection with respondent's error.

REHABILITATION EVIDENCE

11. Respondent was extremely upset and embarrassed by his mistake. It continues to trouble him. He thinks about the incident multiple times each day and is thankful that his patient fully recovered. Following the incident, respondent took a number of steps, described below, to ensure that he will not commit a similar error in the future.

12. Eric Conn, Florida License Risk Manager, met with respondent and performed a risk management assessment of respondent's protocol for his surgical procedures. During their meeting, respondent provided Conn with the following corrective plan:

> 1) Every patient the Physician Assistant sees and deems surgery is necessary, Dr. Shenassa will first see them in the office to examine them himself, review the diagnostic tests and explain the planned procedure in detail with the patient prior to the date of surgery.

[1] At hearing respondent described the 2013 incident as a "near miss," in which no incision was made on the patient's finger. He expressed gratitude that this patient was not harmed.

2) In the operating room the patient will be marked on both the volar and dorsal aspect[s] of the hand.

3) During the prepping process, the site will again be reviewed to ensure the markings have not been erased due to the prep. In the event the marking was erased by the prep, Dr. Shenassa will confirm and re-mark the patient sites prior to any incision.

4) Prior to anesthesia induction and before any incision is made a timeout will be performed with the entire surgical team.

5) A final time out will be performed at the conclusion of the procedure prior to the dressings being applied. If imaging is used, the image will be confirmed that the procedure was performed as planned.

6) If for any reason Dr. Shenassa is required to change positions during the procedure another Time Out will be called again to confirm the operative site.

In a risk management report dated June 5, 2017, Conn agreed with respondent's corrective plan. Conn stated that he reviewed the operative notes of several of respondent's hand surgery patients and was "happy to report that all the protocols are being duly followed and are being properly documented."

13. Respondent's testimony at hearing demonstrated that he now possesses deeper insight into the reasons that contributed to his wrong site surgery in December 2014. Before this incident he only marked the hand and not the finger; he did not take time outs if he changed positions or at the end of a case; he did not sign off on x-rays; and he did not see the patient and the patient's family in his office for a pre-operative visit. Respondent also emphasized the importance of marking surgical sites with permanent markers. The surgery center did not provide for the use of permanent markers at the time of the incident, but it does now.

14. Respondent acknowledges that although he thought he understood the factors that contributed to his misconduct in 2013 and took sufficient measures to avoid the recurrence of his mistake, he realizes that he did not appreciate the importance of implementing the protocols that he now uses in his practice.

15. On May 31, 2017, respondent delivered a lecture at the Weston Outpatient Surgical Center[2] on the topic of wrong site surgery. On September 4, and January 18, 2017, respondent completed courses entitled Taking Time Out to Avoid Wrong Site Surgery, and

[2] Respondent performed the wrong site surgery at this facility.

Preventing Medical Errors. A letter dated August 7, 2017, from Towanda B. Burnett, Compliance Officer for the Florida Department of Health, confirms that respondent completed the terms of the Final Order, and that his Florida license is currently clear and active.

16. Although not required by the terms of the Final Order, respondent engaged the supervision of Alfred A. Desimone, M.D., who is a senior partner at Sports Medicine Associates of South Florida. In a letter dated February 14, 2017, Dr. Desimone writes that he has monitored respondent's case activity for one year, and signed off on each of respondent's surgery cases.[3] Dr. Desimone observed that respondent was "completely humbled and embarrassed by these incidents to say the least." He praises respondent for his professionalism, his "impeccable" bedside manner and his excellent technical skills. Dr. Desimone also notes that respondent is well-respected by his colleagues and patients. Dr. Desimone describes respondent's implementation of new surgical protocols and is "convinced that the steps he has taken and his recognition of the importance of correct site surgery will prevent future occurrences."

17. Respondent will do whatever the Board deems necessary in order to retain his privilege to practice medicine in California.

CHARACTER EVIDENCE

18. In addition to the letter from Dr. Desimone, respondent submitted letters from the following individuals who are familiar with, and think highly of, his work:

a. Alexander Bertot, M.D., has worked with respondent at the South Florida Institute of Sports Medicine for eight years. In a letter dated August 28, 2017, he describes respondent as a competent, dedicated, kind and well-respected surgeon. Dr. Bertot observes that respondent has modified his surgical procedures by adding a time out whenever the position is changed; and marking both sides of the correct digit preoperatively with permanent marker. Dr. Bertot believes that respondent has learned from his mistake, and has increased the awareness of surgeons and hospital staff regarding ways to reduce the incidence of wrong site surgeries. In connection with respondent's learning, Dr. Bertot notes that in his capacity as Vice-Chair of the Board of Directors of the University Hospital in Taramac, Florida, respondent has implemented a new protocol for timeouts for nurses and physicians in the operating room. Dr. Bertot gives respondent the "highest recommendation without any reservations."

b. Mark S. Fishman, M.D., worked with respondent for eight years at the South Florida Institute of Sports Medicine, and submitted a letter dated August 29, 2017, in support of respondent. Dr. Fishman currently practices in a different office, but continues to manage

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[3] Respondent testified at hearing, that he has now been monitored by Dr. Desimone for 18 months.

patients with respondent. Dr. Fishman believes that respondent is a technically excellent surgeon who takes pride in the care he provides to his patients. He also believes that the instances of wrong site surgeries are not an accurate reflection of respondent's skill and competence. Dr. Fishman opines that respondent has truly learned from his mistakes and has implemented new protocols in his practice to avoid the occurrence of a wrong site surgery in the future.

c. Tosca Kinchelow, M.D., has worked with respondent for five years in surgery centers, cross-covering calls, and consulting about patients. In an undated letter, Dr. Kinchelow describes respondent as a conscientious, competent and dedicated surgeon who is well-liked by his colleagues.

Credibility finding

19. Respondent's testimony at hearing was candid and credible in all respects. His respect for his privilege to practice medicine and his remorse for his actions were palpable in his emotionally-laden testimony.

Other matters

20. The New York State Department of Health, Office of Professional Misconduct (New York Department), investigated allegations of misconduct against respondent. A letter from the New York Department, dated February 22, 2017, advised respondent that it concluded its investigation and closed the case without further action anticipated. While the letter from the New York Department is not explicit, it appears that its investigation pertained to the misconduct underlying the Final Order issued by the Florida Board.

21. Respondent is married, with two children, who are 11 and 13 years old.

LEGAL CONCLUSIONS

1. The standard of proof applied in making the factual findings set forth above is clear and convincing evidence to a reasonable certainty.

2. Business and Professions Code[4] section 141, subdivision (a), applies generally to licenses issued by agencies that are part of the Department of Consumer Affairs, such as the Board. It provides, in relevant part, as follows:

> For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action by another state . . . for any act substantially related to the practice

[4] All references are to the Business and Professions Code unless otherwise indicated.

> regulated by the California license, may be a ground for disciplinary action by the respective state licensing board.

The disciplinary action of the Florida Board was based on acts substantially related to the practice of medicine. Cause exists under section 141 to take disciplinary action against respondent's certificate, by reason of the matters set forth in Factual Finding 6.

3. Section 2305, which applies specifically to licenses issued by the Board, provides in relevant part as follows:

> The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state . . . that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

The conduct underlying the reprimand issued by the Florida Board constitutes cause for disciplinary action in California under section 2234 (unprofessional conduct). Accordingly, cause exists under section 2305 to take disciplinary action against respondent's certificate, based upon the matters set forth in Factual Findings 6 and 8.

Disciplinary determination

4. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. At the outset, it is noted that the purpose of these proceedings is to protect the public from dishonest, immoral, disreputable or incompetent practitioners and not to punish the respondent. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for unprofessional conduct under section 2234. The maximum discipline is revocation. At hearing, complainant suggested that a stayed revocation and three years' probation, which deviates somewhat from the Guidelines' minimum penalty, would not be unreasonable, given that over three years have passed since the misconduct. Respondent suggests that the Board should issue a public reprimand pursuant to section 2227, subdivision (a)(4), which would be consistent with the discipline imposed by the Florida Board.

At first blush, it might seem that a probationary order is called for, given that respondent was previously issued a public reprimand for similar misconduct. If principles of progressive discipline controlled, respondent's prior reprimand would, ipso facto, lead to a more severe

level of discipline, the imposition of a probationary term. However, principles of progressive discipline do not control here. Instead, the Legislature has determined that in exercising its disciplinary authority, the protection of the public "shall be the highest priority" of the Board. (§ 2229, subd. (b).) Because the Board's guiding principle in determining the appropriate discipline is public protection, it is through this prism that the evidence must be analyzed. Against this background, the controlling question is what degree of discipline is necessary to carry out the Board's duty to protect the public?

It is determined that a public reprimand, pursuant to section 2227, is the appropriate discipline in the instant case. The facts in the instant case warrant a deviation from the Guidelines for several reasons: In the three years since his misconduct, respondent has taken substantial and meaningful steps to ensure that he never again performs wrong site surgery. Respondent carefully analyzed the factors that led to his mistake and from that, constructed a corrective plan to improve his surgical procedures and remove the possibility of performing a wrong site surgery in the future. That plan was approved by a risk manager, who reported that respondent has properly implemented and documented the new surgical protocols. Respondent completed the requirements of the Final Order, and he also went beyond what was required by engaging Dr. Desimone, a senior doctor in his practice to directly monitor his case activity. Respondent has been supervised by Dr. Desimone for 18 months, and received a glowing recommendation from him.

Respondent's genuine testimony and insight into the reasons underlying his misconduct, coupled with implementation of his new surgical protocols, lend credence to his promise that this event will not occur ever again. Respondent's demeanor at hearing demonstrated that he holds his privilege to practice medicine in extremely high esteem and that he has been chastened by his misconduct. Respondent's expertise and professionalism as a hand and wrist surgeon have earned him the respect of his colleagues, who uniformly view him as an extremely competent and compassionate doctor.

Additionally, it is noted that the Florida Board has determined that respondent can practice safely without the need for imposition of a probationary term; and the New York Department investigated respondent's misconduct and closed the case without instituting any disciplinary proceedings against him.

In consideration of these factors, it is found that a public reprimand is sufficient to protect the public interest. In conjunction with respondent's public reprimand, he will be required to complete a course in wrong site surgery.

ORDER

Respondent David Shenassa, M.D., is publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). Respondent shall enroll in a course pertaining to the subject of wrong site surgery, approved by the Board, within 60 days from

the effective date of this decision, and shall provide proof of his completion of the course no later than six months after his initial enrollment. This course shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licenses.

DATED: December 4, 2017

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Diane Schneider
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DIANE SCHNEIDER
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAVID SHENASSA, M.D.** 1600 Town Center Circle, Suite C Weston, FL 33326-3641 Physician's and Surgeon's Certificate No. A102331, Respondent.	Case No. 800-2016-028436 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On December 14, 2007, the Medical Board of California issued Physician's and Surgeon's Certificate Number A102331 to David Shenassa, M.D. (Respondent.) The Physician's and Surgeon's certificate is renewed and current with an expiration date of April 30, 2017. Prior disciplinary action has been taken as follows: On March 5, 2014, an Accusation was filed against Respondent in Case No. 800-2013-000265, and on July 17, 2014, a Decision became effective which read: Public Reprimand.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
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> "(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

4. On December 7, 2016, the Florida Board of Medicine issued a Final Order regarding Respondent's license to practice medicine in Florida. The Final Order resolved a pending Administrative Complaint alleging that Respondent performed a 'wrong site' finger surgery on a 10 year old patient. Under the terms of the Final Order, Respondent's Florida license was reprimanded and a fine imposed. Terms and conditions of the Final Order include a requirement

that Respondent engage an independent, certified licensed risk manager to review his practice, complete continuing medical education, present a lecture to surgical staff on the subject of wrong site surgery, and pay a fine. A copy of the Final Order and Administrative Complaint issued by the Florida Board of Medicine is attached as Exhibit A.

5. Respondent's conduct and the action of the Florida Board of Medicine as set forth in paragraph 4, above, constitute unprofessional conduct within the meaning of section 2305 and conduct subject to discipline within the meaning of section 141.

MATTER IN AGGRAVATION

6. In a Decision and Order effective July 17, 2014, in Case No. 800-2013-000265, Respondent's certificate was publically reprimanded based on an order issued by the Florida Board of Medicine, under which a Letter of Concern was issued, and Respondent was required to complete courses in medical/legal ethics and rules and risk management and to present a lecture on wrong site surgeries. The Florida order resolved allegations that Respondent preformed a "wrong site" surgery and failed to take the required steps to prevent a "wrong site" surgery.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A102331, issued to David Shenassa, M.D.;

2. Revoking, suspending or denying approval of David Shenassa, M.D.'s authority to supervise physician assistants;

3. Ordering David Shenassa, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: March 3, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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